tions for the care of the chronics and the convalescents? Has the integration of the dispensary with the hospital proceeded along the line of best medical thought? Are our hospitals making the most of their opportunities for the advancement of medical science and the improvement of general medical practice? Are we making available to the general public the facilities which the hospitals can give extra-murally? Has there been a sufficient linkage between the hospitals and the public health movement or preventive medicine? Are the hospitals and the out-patient clinics, free and pay, engaged in an unfair competitive relationship with the medical practitioners? Can the modern hospital organization make possible a larger participation in hospital work on the part of "family physicians?" Is the very recent idea of recruiting large groups of the population for the broadening of hospital support through the purchase of hospital service on an insurance basis going to exert a beneficial or harmful influence on the hospitals themselves? Have we gone too far or not far enough in providing hospital care through taxation?

These are but a few of the questions to which earnest thought must be given on the part of citizens of responsibility and of physicians interested in the evolution of social and medical ideals and institutions.

THE PSYCHIATRIC APPROACH OF THE PRACTITIONER TO HIS PATIENTS*

MORTIMER W. RAYNOR

Psychiatric problems are not new in the practice of medicine. It would seem though that mental illness is gradually becoming more prevalent and that now, more often than ever before, the practitioner has it to deal with. It may be true that there has been an increase in the incidence of psychiatric disorders as well as changes in their manifestations. This apparent increase, however, may be accounted for in various ways. Within comparatively re-

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cent times the physician has come to recognize and to understand psychiatric cases more easily. Coupled with this growing interest among members of the profession, there has been a corresponding growth in sympathetic concern on the part of the public. And, further, because mental illness has lost many of its unpleasant associations, people do not hesitate, as they used to, to consult a physician about their difficulties and to seek treatment for themselves or for relatives.

At the risk of being trite I shall refer briefly to attitudes toward mental illness which have been held in the past. In doing so, I do not wish to be considered over critical but I do desire to show the change which has come about and the contrast obtaining between the older and the more modern conceptions. These outmoded ideas must still be reckoned with and, if necessary, arbitrarily laid aside as interfering with the understanding and treatment of mental disorders.

Not so long ago both the profession and the community thought of psychiatric disorders in terms of "insanity" and of the physician who interested himself in mental disorders as an "alienist." Both the professional and community responsibilities were satisfied when the patient was duly examined and committed as an "insane person" to an "asylum." The "family skeleton" was then "safely locked in the closet." This was a perfectly good legal point of view and it was undoubtedly an improvement over the still remoter past. If the patient recovered he returned home with a cloud over him. His family and his friends lacked confidence in him and the neighbors felt sorry for him and said there must be "a bad streak in the family somewhere." Perhaps the patient's symptoms were not so marked—note the matter of degree—that he needed "to be put away." Then both the profession and the community thought in terms of "nervousness" and physicians undertook the treatment of the patient. Generally his case was diagnosed as one of the many current variations of "nervousness." He was "run down" and was given a tonic, or he was

troubled with insomnia and was given a sedative. He was then patted on the back and told that there was nothing the matter with him and was sent away on a trip or to the country for a few weeks. Sometimes a somatic disorder was diagnosed and treatment was given accordingly, or else he was looked upon as a hypochondriac. In the latter cases as time went on, the patient became a chronic invalid, drifted away from the doctor and became the support of some quack or cult, or worked out some religious, dietary, or physical culture nature cure and got along as best he could.

If one goes back to the latter part of the eighteenth century he will find the first evidence of real medical interest in the study of these problems. Slowly a body of psychiatric knowledge has accumulated which again and again has changed viewpoints and enlarged horizons. Many hypotheses concerning the causes of mental illness, its development and treatment, have been advanced. As a result there has appeared to be considerable confusion in psychiatric terminology. This has been no different from nor harder to understand than what has taken place in other branches of medicine. During the last several years of signal advances in medicine, it has been necessary to become acquainted with the language and terminology of the new discoveries in immunity and biochemistry, for example, as well as with those in psychiatry.

In this paper I do not propose to discuss the classification of psychiatric disorders. One can understand the factors at work in bringing about a patient's illness without such information. However, if any one is sufficiently interested, he may find the present system of classification, which at best is unsatisfactory, in any standard textbook on Psychiatry (1). Neither shall I attempt to say anything of the treatment of the mentally ill, which is a subject in itself and may well be left to another time. I have prepared this paper not for the psychiatrist who is already familiar with psychiatric formulations and their applica-

tion, but for the physician who meets psychiatric problems in his daily medical practice.

I do not consider it profitable now to be concerned with the concepts of "insanity" and of "nervousness" and their differentiation, nor with the degree of deviation represented by such terms as "severe" and "mild," "normal" and "queer." It is important though that they be recognized, in the last analysis, as all coming out of the same pot.

The wide use of the expressions "personality" and "the reaction of the individual as a whole" makes it imperative that they be used advisedly in order to avoid loose thinking and snap judgment. The term "neurosis," with its qualifying adjectives of "gastric," "cardiac," "sexual," etc., should be looked upon as not stating the facts entirely and also with the suspicion that the "physical" and the "mental" and the "emotional" are being differentiated instead of the problem's being looked upon as a total reaction of the individual. The following case, in its opportunity for a wide range of diagnoses, illustrates this point. The patient, following an adequate cause, developed at different times syndromes of (a) spasticity of the extremities; (b) coarse tremors; (c) flatulence, heart burn, epigastric pain, and anxiety; (d) rapid pulse, pain in the region of the heart, rapid and difficult breathing, with extreme paleness and giddiness; and (e) periods of marked emotional depression when these other symptoms were not in evidence. These syndromes ushered in a prolonged depression without organic disease.

Thus it is important that the acquaintance of current viewpoints be made and also that they should not be accepted in the abstract but tested in the light of clinical studies of patients. It is not my intention to review these various schools of psychiatric thought and their development. There are probably few here who are not more or less acquainted with the current psychobiological and psychodynamic formulations of among others, Freud [2], Janet [3], and Adolf Meyer [4], and the very excellent critical reviews of their several hypotheses [5] [6].

In our present state of knowledge it is essential that the facts of the clinical histories and examinations be kept clearly in mind, that obviously unrelated data are not forced together in order to arrive at formal diagnoses, that enthusiasms are not mistaken for clinical data, and that emphasis is put on the understanding of the symptoms in relation to the development and experiences of the patient.

The study of the evolution and of the history of the complete development of the individual is essential to a thorough understanding of the patient from a psychiatric point of view. Constitutional traits, experiences, and resulting tendencies are often referred to as the personality make-up. It is clear that the personality make-up is not static but potential and dynamic. It is in a constant state of evolution, sensitive to both internal and external situations, and is being modified in one direction or another as a result of each individual experience. It should not be thought of as a ball which may be pushed hither and thither without direction. In the course of its development it does gather direction and a main tendency may be discerned within the usual life experiences. This is so even when superficially there appears to be marked and radical deviations.

It is perhaps well, even at the risk of attempting to over-simplify them, to call attention to a few steps in the evolution of man. With the union of the two cells tremendous forces are brought together which include traits not only of the family but of the whole history of the race as well. In referring to the germ cells, Harvey (7) says: "Their continuity links us with our ancestors, even the most remote. Our life is their life continued." The development of the embryo in the differentiation of tissue and the building up of whole structures, layer by layer and system by system, reflect the whole evolutionary history of man from the earliest forms of life. Of special importance to psychiatry is the evolution of the nervous system and the special glands of the body. An understanding of these forces and mechanisms during intra-uterine life

helps us to explain certain obscure and archaic reactions [8] [9] seen in the clinical manifestations of patients.

As soon as he is born the individual meets an entirely new environment and has to make new types of adjustment. Old drives, satisfactions, and habits have to be given up. The ever-increasing pressure of the environment makes a radical change in the demands upon the individual. The instincts of self-preservation, of the propagation of the race, and of seeking satisfaction as an individual and as a member of society, call for new adjustments of the highest and most important order. The constant striving from within and pressure from without forever call for the making of new adaptations. New habits and satisfactions instantly become inadequate and have to be given up in part or in whole, to be replaced by ones which in turn meet the same fate. This endless interplay of forces results in conflicts and compromises. It must be apparent that the resulting compromises often only partially satisfy the various strivings. The individual of course is aware of only a few of these activities, conflicts, and subsequent compromises. Most of the activities, because they are not salutary and acceptable to the conscious life, are repressed into the unconscious. The mechanism of repression is an automatic mental process not under the control of the conscious life of the patient and it applies both to the content of ideas and complexes and to their affects or emotions.

Mental activity is made up not only of ideas or concepts but also of their accompanying affects or feeling tones. The affect may become detached from its original concept and attached to an altogether different concept. When any part of the repressed material and its affect break through the repression into consciousness, their genesis is not recognized and they appear in a highly disguised form. This is especially seen in conversion hysteria and is illustrated by the case of a painter who developed a complete paralysis of his right forearm after an altercation with his wife, who accused him of not earning enough money to support her as she desired. Neither the man nor his wife

saw the connection between the altercation and the paralysis.

Wherever the process of development meets with differentiation and full satisfaction is not obtained and complete adjustments are not made, psychologically vulnerable spots remain which are referred to as points of fixation. At these points also arise the partial tendencies or satisfactions which often have to be dealt with later.

It is therefore most important in the study of psychiatric cases that a full history be obtained in each, and that the essential facts concerning the constitution and life history be studied and evaluated, as well as the data concerning the immediate situation.

In practice the immediate approach in the psychiatric study of the patient is made, as in all medicine, at the level of the complaint which brings the patient to the physician. A cross section is made of the personality make-up and the soma at this point, and attention is directed to the data at hand. When all of the immediate facts have been obtained, a complete history, or longitudinal survey, is obtained. Cross sections are also made at such levels as appear to give opportunities to study the process of the individual's development. The data is then evaluated and put together. If the study has been reasonably successful, a good understanding of the predisposing and precipitating causes will be evident, and adequate treatment may be undertaken.

In the consideration of constitutional factors the questions of direct hereditary transmission or hereditary tendencies to psychiatric disorders merit attention. Many studies have been made in this field and there is considerable discussion as to their importance. There is much that is highly suggestive and not so much that is positive, except that psychiatric disorders do recur in certain families. In estimating correctly the importance of any family traits or tendencies, one must bear in mind as well the inherent psychology of the family, and intra-family influences, as

I indicated some time ago in my paper on the "Problems in the Prevention of the Functional Psychoses" ([10]). Whatever the situation may be in regard to heredity, it must not be allowed to influence one unduly in his endeavor to treat the patient, any more than a family history of cancer or of tuberculosis influences physicians in their attempts to cure or to arrest these diseases.

Studies of the somatic constitution have been more helpful. Kretschmer ([11]), Gibbs ([12]), Roper ([13]), and Draper ([14]), have attempted in a most suggestive way to correlate the somatic findings and the personality make-up. Unfortunately, studies of the ductless glands and the autonomic nervous system have not been, except in a few outstanding instances, so productive and helpful, and caution must be exercised in assigning any known causative importance to them. It is, however, hoped that more studies like those made by Cannon ([15]) may be undertaken. They will undoubtedly throw much light upon the physiological side of psychiatric problems. Kretschmer described body types which he correlated with types of temperaments. Gibbs studied the secondary sex characteristics in psychotic patients. In a study of body hair growth in women in whom he found the male distribution, he says in part, in discussing the biological interpretation: "The findings [in manic-depressive cases] and those previously reported in dementia praecox indicate the presence of an inter-sexuality or biologic bisexuality. . . . The degree of development and functional capacity of the feminine factors, both physiologically and psychologically, seems to vary considerably in these patients and apparently in an inverse ratio to the development of the masculine factor. . . . It seems quite possible that the presence of a certain degree of masculinity may account for the sexual drive which some of the patients present, with the resulting illicit relations. . . . As these patients grow older the ovarian or feminine function fails, with the masculine element gaining the ascendency." He also pointed out that in certain female cases of dementia praecox presenting masculine distribution of hair, small uteri and breasts, childish body contours and faces were

found. These few references will indicate some of the directions in which helpful studies of the somatic constitution have been made.

The study of the past history of the patient and his personality make-up is time consuming and often that is one of the reasons which deter the practitioner from making a thorough study of the patient's disorder. Often this fact is also the cause of the physician's failure to help the patient. Foster ([16]) expressed this clearly in reporting a most instructive case. He said, "It took both time and trouble to find the cause of this sensation." However, if the doctor will take the time to study a few cases he will be rewarded by the results attained and the ability he will develop in reducing the necessary time spent on a case.

In psychiatric examination and history taking, it should be borne in mind that the inquiry must be broad and include both the psychological and the somatic sides. The important psychological and physiological periods should be given special attention since extraordinary stresses are met at these periods. It is often at these times that adjustment fails or becomes seriously impaired.

After the family history has been taken, inquiry should first be made as to the condition of the mother during the pregnancy and labor. This is followed by questions about the physical status of the infant during the first year of life; the nursing and weaning problems; the age of walking and talking; the child's reaction to training in the control of the bladder and rectum; the disposition, whether happy or fretful; the occurrence of tantrums, fears, night terrors; and the regularity of growth. These all have to do with the new adjustments the individual has to make in his development and contact with the environment. Difficulties in taking the breast or the bottle, or in giving them up, are common enough. Often they are points of fixation which are the foundations of later disorders, or they may be the first of a series of defective adaptations to life. Their immediate importance is whether or not they fit into the picture of the later psychiatric disorder.

Inquiry should also be directed to tracing the patient's intellectual growth and social development from early to later life. A study is made of the early evidence of sex manifestations, both physiological and psychological. Among the changes inquired into are: in boys, growth of the genitalia, change of voice, and shaving; in girls, development of the breasts and menstruation. In both sexes masturbation which may begin in infancy as well as in later life, should be investigated. The beginning of sex activity, changes in it, and any deviations should be ascertained. In women special attention should be given to pregnancies, children, and the menopause. On the psychological side, it is well to inquire of the mental attitude of the patient toward these events and changes and to ask about early interests and curiosities, adolescent interests, love affairs, and attachments to either or both of the sexes. Sex perversions are partial tendencies which have not been sublimated.

At this point in the study it is well to get a picture of the family, the family life and atmosphere. Their relations to each other and to the patient, and the patient's attitude toward the several members of the family, the likes and dislikes, somatic and psychological resemblances, and the attachments one for another are of great importance. In this connection the reciprocal relation between the patient and his parents, and their relation to each other, are often of great importance to the future mental health of the patient. As I have previously shown, many of the habits of thinking and reacting are acquired by example and training. Weak, insecure, irritable, fault-finding and self-centered parents are by imitation and training the source of similar traits in their children. Over-severe and domineering parents frequently cause quirks of the personality which handicap a patient throughout his life. The lack of instruction and of force of example in training children in the ordinary habits of personal hygiene, of eating, of handling instinctive urges, and in social values are psychological factors which have a great bearing on the development of the personality.

A history should be taken of injuries and physical illnesses, including exposure to toxic influences and the use of alcohol and drugs, including medication. The patient's attitude toward them should be ascertained also.

It is important to know something of the patient's output of energy as shown by his ability to apply himself to recreation and work, to learn his feelings about his inner self and toward other people, his attitude toward his environment and community life and responsibilities, the practicability of his ideas about the realities of life and his interest in abstract and mystical subjects and in superstitions, the range and quality of his emotional reactions, and his general feeling of adequacy or inadequacy toward his responsibilities and life. In taking the history it is well to make special inquiry into reactions toward outstanding situations in the patient's life, such as disappointments in career and love, deaths and marriages in the family, and any other outstanding events. The occurrence and nature of any previous attacks should be ascertained.

I think when the essential facts of the inquiry are summarized, it will be found that there are tendencies toward preferred reactions and that similar or related situations tend to bring out similar reactions.

The study of temperaments, which belongs to the ages, has been discussed by many. However the study of their relation to defects in adjustment is more recent. Hoch ([17]) pointed out the relationship between the personality and later maladjustments. He said: "Therefore, both the pathological personality, with its milder manifestations; and the psychosis, with its more complete break of compensation, may be looked upon as determined by constitutional factors, in the sense that when demands for adaptation arise the individual is found unfit to meet them, unfit through inherent weakness, but also at times, to quite an extent, through false attitudes which have developed through lack of proper training." He described the so-called "shut in" personality which sometimes leads

the patient into a malignant type of psychosis. Bleuler ([18]) formulated cyclothymic and schizoid reactions as types of personalities found in "normal people" and which often lead to pathological states.

The following cases will illustrate the foregoing.

A young woman of 31, the youngest of eleven children, had great difficulty in obtaining a much desired education, because of the poor financial status of her family. She had to work her way through college and this was done under a great deal of tension. She was sensitive, did not make friends easily, and did not talk of her difficulties. She felt inferior to her associates and was inclined to be suspicious. At home, under the influence of her dominating father, she was submissive; but after she left home, she became self-assertive and no longer took advice and direction well. Consequently she always worked alone in so far as possible. At the time of her graduation she cried three days without any explanation. She then became a technician of microphotography and in this position she was required to spend a great deal of time in the dark room. Her menses began at 12 and at these periods she was moody and more seclusive. She developed a fondness for one of her male associates and finally spoke of it to her roommate. Immediately she began to be suspicious of her roommate. She thought the other people in the laboratory knew of it, that remarks which had a special meaning were passed in her presence. She finally became very suspicious of everyone about her and developed bizarre ideas of influence and that she had been the subject of experimentation. In reaction to her delusions her conduct became increasingly peculiar.

A woman of 38, a writer, who had always been of an "up and down" temperament, developed after some years of writing, an acute exhilarated state when one of her books had been accepted for publication. Thereafter she had three episodes. Of the four, two were elated attacks following acceptance of her books by a publisher and two were depressions when publishers refused her books. These

attacks never lasted more than three weeks. They were exaggerations of her natural make-up and were recognized by her as reactions to these specific situations.

In the study of the present illness a good account of the patient's complaint and the setting in which it developed is most important as is the patient's opinion as to why it developed. Early in the disorder most of the precipitating factors will be found in the account as given by the patient, but as time goes on, one will find that these have faded out and more remote matters and rationalization have taken their place. The mental trends and the account of the psychological moment of onset often give a direct clew to the whole situation and mechanism of the disorder. Therefore the earlier one sees cases and the more complete the account of the onset obtained, the better the case is understood and the more sure one can be of helping the patient.

As many patients complain of somatic symptoms, it is most important to secure a good account of the circumstances which led up to them and the particular factors which finally precipitated the symptoms. These cases are often difficult to differentiate and understand, and give much concern to the physician. A careful inquiry should be made as to the presence of any acute somatic disorder, and if there is one, restraint must be exercised in ascribing undue importance to it in the presence of psychological symptoms. There is of course no question but that somatic illness may be the cause of psychiatric disorders, that it may materially influence the course of the psychiatric disorder, that it may itself be obscured by psychiatric symptoms, or that the two may be concomitant without materially influencing the course of either. Then, too, in acute psychiatric disorders there are physiological changes, among which may be vaso-motor disturbances, increased basal metabolism and sugar metabolism in elated states and retardation of the same in depressed and apathetic states. Henry [19] has reported that hypotonicity and

hypomotility of the intestinal tract are found in depressed states; in anxiety states, hypertonicity and hypomotility. In an unpublished study of menstruation, Henry found that in intense painful emotional states as in depressions, there is a cessation; and in painful emotional states associated with schizophrenic syndromes there is an irregularity in frequency and duration. A careful study of the case and a judicial weighing of all the factors, both somatic and psychological, brought out by a painstaking history, will ordinarily clear up any doubts.

Physical disorders sometimes impair the psychological defense mechanisms and act as a release to personality disorders which then dominate the clinical picture. These symptoms often disappear when the physical disorder has been corrected. This is illustrated in the following case: A woman of 38 had always been subject to mood swings; when up, she was active and showed erotic tendencies; when down, she was serious and inclined to keep by herself and was introspective. She had for a long time suffered from dysmenorrhea and later menorrhagia. When first seen she showed impulsive and silly conduct, heard voices speaking, expressed paranoid trends, and at times was mute and drew pictures of dolls. She showed a marked anemia and had lost twenty pounds. During the course of her treatment as her blood picture improved, all her mental symptoms disappeared. Although she was warned of the necessity of keeping in touch with her physician, approximately a year later it was learned that she had married and that there had been a return of her mental symptoms, preceded by menorrhagia. Later when she was seen, she presented the same mental symptoms and in addition she accused her husband of unfaithfulness. Physically she presented a picture of severe secondary anemia and a marked loss of weight. Again rest in bed and treatment of the anemia brought about improvement in her blood condition and her psychological condition. Since the second attack she has kept in touch with her physician who has watched her blood picture, with result that at least one other attack has been prevented.

Somatic conditions also often act as precipitating factors and the means through which the personality can express itself in terms of psychopathology. This is commonly seen in the psychiatric disorders accompanying childbirth, labor and parturition. This has been shown by Zilboorg ([20]) who also pointed the way to prevention.

In addition to the above we have the typical organic mental reactions ([21]) ([22]) which are directly dependent upon somatic disorders. They are generally found in toxic and exhaustive states or degenerative disorders such as senility, arteriosclerosis, and other diseases which cause changes in brain tissue. Delirium, confusion in the sense of defective orientation, hallucinations, paranoid trends, and Korsakow-like syndromes are psychological symptoms typical of these reactions. They may be obscured by other psychic symptoms as a result of a more extensive involvement of the personality reaction. Kirby and Davis in a paper on the "Psychiatric Aspects of Epidemic Encephalitis" give a good clinical picture of the organic reaction types ([23]).

Time does not permit me to discuss the psychological symptoms which accompany neurological disorders. The same statements made concerning somatic disease apply with equal force to disorders of the nervous system. Some of these disorders have their special psychological syndromes.

In major hysteria we find some of the most typical instances of somatic symptoms due to psychological causes and arising in a psychological setting or even a somatic one. Cases of hyperthyroidism precipitated by emotional causes are not uncommon. Everyone is familiar with the vaso-motor phenomena occurring in fright and embarrassment, the gastro-intestinal symptoms of a student at examinations, and the similar symptoms often associated with worry. In addition to these perfectly obvious cases, others present obscure somatic symptoms which often have psychological determinants. In these cases it is found that the affect has become disassociated from a concept

and displaced to a somatic system or syndrome which has some degree of similarity to the original cause as if it were real. Cases of spurious pregnancy with the accompanying distension of the abdomen and enlargement of the breasts in women fearing or longing for pregnancy, and cases of morning vomiting in the same situation, are known to all.

The following case reported by Foster ([16]) is of interest. A married woman consulted her physician for a disorder of the heart. She had never had any trouble with her heart previously. She complained that after walking even so short a distance as half a block her heart jumped and caused distress. She had feelings of oppression and sensations of choking. As long as she stayed at home she did not feel discomfort. Once she had ventured on the street and had gone no further than half a block when, overcome by a state of terror, she rushed home. Inquiry finally developed the information that on a certain day she had seen her husband and a woman of whom he was fond, walking arm in arm. She had at once felt jealous and "terribly disturbed." She immediately returned home and stayed in the house for several days. When she attempted to go out she was overcome by distress in the region of her heart.

Among some of the common complaints for which patients seek assistance from their physicians are "nervousness," "run down" and tired feelings, inability to concentrate, anxiety, depression, insomnia, irritability, tenseness, headache, indigestion, and constipation. These may all be psychiatric symptoms and indications of difficulties of adjustment. In the course of life experiences, many strivings which cannot be satisfied and many compromises which are not acceptable have to be sublimated by turning them into useful channels or activities. The failure of sublimation often accounts for some of the less marked defects in adjustments. The young woman who for some reason is denied marriage and motherhood may successfully take up nursing. Later the sublimation may

not be sufficient for her needs and symptoms may appear without any immediately discoverable cause. This is the situation in many patients. It is just as important to look into the history of these patients for adequate causes as it is in the more severe cases. It is a recognized fact that the earlier the recognition of the underlying causes, the greater the probability of satisfactory readjustment. Particularly is this so in those emotional deviations, especially depression and anxiety, which are associated with thoughts of inadequacy and self reproach. Most of these patients meditate in one form or another on death. Such patients should without exception be looked upon as likely to make suicidal attempts. The great majority of them are hopeful cases.

Everyone, the world over, rationalizes his lack of knowledge and understanding, his mistakes and successes, his inadequacies and potentialities. And so, both the patient and the physician constantly tend to rationalize the patient's symptoms and state of health. This psychic mechanism is something against which every physician must be on his guard. He should not accept too readily the nearest explanation, the most plausible reason or the conventional one. Hard work and over study do not bring about a "nervous breakdown" unless there are conflicts connected with them in some way. Worry is always associated with insecurity because it denotes a lack of understanding or a feeling of inadequacy in meeting problems.

Mental health indicates an adequate level of integration of the whole biological unit, which in this case is a person. Anything, psychological or somatic, internal or external, which interferes with the integration impairs the adjustment the individual must make to life and to reality. The type and the degree of the impaired adjustment will depend upon the quality of the integration of the personality make-up in its largest sense, the psychological value of the precipitating cause whether it be psychic or organic, and the mechanisms present in the reaction. These can be known and understood only through a careful mental and physical examination.

The foregoing sketches in a general way the trend of thought in approaching psychiatric problems. Those who desire to become further acquainted with this subject will find in the following bibliography references which will stimulate their interest and broaden their understanding.

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REVIEW OF "POLIOMYELITIS"

A Survey Made Possible By a Grant From The International Committee For The Study Of Infantile Paralysis.

On the initiative of Mr. Jeremiah Milbank of New York, founded on his desire to make a substantial contribution toward the solution of some medical problem connected with the diseases of children, and with the munificent donation from him of $250,000 supplemented three years later with $30,000 additional, there was organized in April 1928 the International Committee for the Study of Infantile Paralysis. The Committee consisted of fifteen distinguished scientists and physicians in the United States and England under the Chairmanship of Dr. William H. Park; it organized and directed the collaboration of over 40 research workers, who, in their different laboratories and institutions in separate centers, began work on such phases of the disease as they felt best qualified to study and to attempt to solve.